Chaplain Service

Base Chapel
16 SOW/HC
Commercial (850) 884-7795
DSN 579-7795
E-Mail
http:www.afsoc.af.mil/hc

OR

Command Chaplain's Office
HQ AFSOC/HC
Commercial (850) 884-4649
DSN 579-4649
E-Mail
http:www.afsoc.af.mil/hc

Chaplain Service

LETTER OF INTRODUCTION

Suicide is not a spontaneous act. People who are suicidal do not simply wake up one morning and decide “Today’s the day I’m going to kill myself.” On the contrary, suicide is usually a gradual, long-term process. The person’s will and faith erode to expose what they perceive as insurmountable disappointments in their life.

This prolonged process leading to the life-or-death crisis makes many suicidal people ambivalent about dying when they truly wish to be rescued. About 75% of suicidal people will give notice of their intentions in the form of early warning signs. Some will do so because they are trying to find out if anyone really cares if they live or die. Therefore, it is imperative that the early warning signs be recognized.

All supervisors and managers are the front-line defense against suicide. Please “keep an eye” out for anyone in your organization that is experiencing personal and/or financial problems. Please read this booklet and use the information to better understand the warning signs of someone contemplating suicide. Utilizing this booklet can help you recognize the early warning signs and initiate prevention strategies before it’s too late.

FRANK P. MAYERNICK, Ch, Lt Col, USAF
Suicide Prevention Program Director

About the Problem of Suicide

- 100,000 actual suicides in U.S. each year
- Women three times more likely to attempt it
- Men four times more likely to be successful
- Suicides by rank - ENLISTED (based on '97 AFOSI statistics)
  - A total of 41 enlisted suicides - Staff Sergeants represented the highest number of suicides with 11; the lowest number with one suicide were the grades of E-2 and E-9
- Suicides by rank - OFFICER (based on '97 AFOSI statistics)
  - The total officer suicide population was four - Only the ranks of O-3 through O-5 had at least one suicide; the rank of Captain was the highest with two suicides
  - There is an average of 67 suicides per year by active duty Air Force personnel
  - Marital Status: A total of 18 individuals who committed suicide were married - this represents 40% of the active duty suicide population - the next largest category was single who made up 33% of the population

Know Your Personnel

- Be keenly aware of changes in attitude, behavior, and job performance
- Marital, alcohol, emotional, financial, and judicial actions are contributors of suicide attempts
  - Be especially alert if more than one of these occur together
- Be available and supportive to your people - let them know you are willing to talk about things that are troubling them
- Identify "at-risk" personnel and get them help

Know the Warning Signs of Suicide

- Major depression is leading cause
- Current trauma, arrest, or sudden loss
- Talking openly about suicide (almost everyone who tries will talk to someone about it prior to the act)
- Giving away possessions; putting affairs in order

- Early abuse as a child; developed sense of unworthiness
- People who have had family members commit suicide are at higher risk - suicide can often run in families
- Sudden improvement in personality or attitude that is not warranted by an external situation (can be very dangerous, may indicate that a decision is made perhaps for suicide)
- Prolonged grief after a loss
- Among teenagers, substance abuse is a major factor - family conflict is another major factor
- 78% of suicides had a "significant event" just prior to the suicidal act (a father was confronted with charges of incest, an airman was arrested for DUI, a person was fired from work, etc)

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Know How to Help Someone Who is Thinking Suicide

- Be direct
  - Talk openly by asking questions like:
    - Are you depressed?
    - Are you thinking about hurting yourself?
    - How are you planning this?
    - Are you thinking of suicide?
    - Will you talk to someone who can help you?
- Be a good listener
  - Listen with your eyes as well as your ears
  - Look for nonverbal clues
- Take threats seriously
- Refer to mental health immediately
- Answer cries for help
  - Don't ignore the issue
  - Offer support and understanding
  - Make the appointment for the individual
  - Make sure they go to the appointment
  - Did the appointment help?

Know Your Resources

- Actual threat should be referred to Mental Health <u>immediately</u>

- Troubled individuals who may not be suicidal should be referred to a chaplain or counselor at the Family Support Center
  - These professionals can assess the actual suicide risk
  - If in doubt – refer!
- Never leave a suicidal person alone
  - Contact someone who can help and wait with the person until help arrives
- Don't sidestep or minimize the issue
  - Avoid offering empty reassurances such as "Don't worry" or "You shouldn't feel that way" or "You have it a lot better than most people"
  - Assure the person of help and assist them in getting help
- Invite a mental health officer and chaplain to your unit following any suicide or suicide attempt
  - Part of suicide prevention is to debrief the unit after traumatic events
- Invite your unit chaplain to commander's call to give a short briefing on suicide prevention

Suicidal Risk: Evaluation and Prevention Strategies

Although suicide appears uncommon, it is among the top ten causes of death in the United States. There are certain "demographic" features that stand out for suicidal individuals, as well as characteristic psychological features and experiences that put some people at risk for killing themselves. Since these depressed and suicidal people are desperately in search of any solution to their problems, it is possible to intervene and prevent this self-destructive act. To do so, it is necessary to know how to intervene, and to make appropriate referrals.

- Suicide is an unfortunate cause of death; it's a permanent solution to a temporary problem and is becoming more common
- It is a leading cause of death among those aged 25-44, but affects all age groups
- "Successful" suicides are among males; more females make "gestures"

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- "Successful" suicides are among males; more females make "gestures"
- There is some variation in suicide rates according to race and religious background

- It tends to follow significant emotional and interpersonal problems

- Suicide prevention is initially based on recognizing the "danger" signs
  - The "failure tunnel" is a model describing the downward spiral for those at risk
  - There are specific signs and symptoms indicating immediate risk that can be evaluated
  - Emotional symptoms, stress, chronicity, suicidal plan, resources, prior suicidal/psychiatric history, medical status, communication, and lethality are all critical components to examine
- Effective suicide prevention also requires action
  - Since most suicidal individuals are ambivalent about killing themselves, they can be helped
    - They are likely to first communicate their hopelessness and despondency to their friends
    - If you suspect someone is suicidal, ASK - It won't give them the idea or make them do it (usually it's a relief)
    - Take any suicidal threats seriously - the consequences of not acting will be more serious than the consequences of acting
- Utilize appropriate resources
  - The "buddy system" is a good front-line intervention
  - The chain of command can help
  - Clergy—military or civilian
  - Mental Health
  - Off-base Champus providers

Suicide can be a preventable condition. In order, to stop such behavior, it is critical to identify suicide risk in terms of general and specific risk factors. We can inquire about suicidal ideas and intents, and deliver the person to someone with greater expertise if the problem is beyond your means.

Conclusion

Suicide cannot be eliminated, but a great deal of it can be prevented. We must balance the needs of the mission with the needs of the people. When people have problems, they need someone to whom they can talk and trust. You can be that person.

OTHER PROGRAMS and CONTACTS

Marital Dysfunction	
Chaplain Service Center	884-7795
Mental Health Clinic	884-4237
Family Support Center	884-5441
Grief Recovery	
Chaplain Service Center	884-7795
Divorce Recovery	
Chaplain Service Center	884-7795
Stress/Anger Management	
Mental Health Clinic	884-4237
Family Support Center	884-5441
Alcohol Abuse	
Mental Health Clinic	884-4237
Spouse Abuse	
Family Advocacy	884-5061
Financial Management	
Base Finance	884-4102

NOTES:

Ministry Resources

Suicide Prevention Crisis Management

Suicidal Risk Assessment Checklist

The following checklist of questions should be used when assessing the potential for suicide base on the content of the booklet.

I. Background

A. Personal

1. Sex _____

2. Race _____

3. Age _____

	Yes	No	Unk
***4. Has the person attempted suicide before (*Consider lethality, see D.I.R.T.*)?**	___	___	___

B. Family

***5. Any history of suicide in family?**	___	___	___
6. Any chronic illness of parent during childhood years?	___	___	___
***7. Does person come from a broken home (*death or separation from one/both parents before age 16*)?**	___	___	___

II. Stressors

A. Losses

***8. Any loss of significant people in life within the past six months (*divorced parents, friends, break-up of romance, death of friend or role model*)?**	___	___	___
9. A recent humiliating experience?	___	___	___
10. Has person dropped extra-curricular activities?	___	___	___
11. Has person dropped out of school?	___	___	___
12. Has person lost his/her job?	___	___	___
13. Has person moved within past 6 months?	___	___	___

B. Medical

14. Has person been in a serious car accident due to speeding or chemical abuse? Any apparent accident proneness? Has person exhibited self-mutilating behavior (head banging, burning self)?	___	___	___
15. Has person had a previous psychiatric hospitalization?	___	___	___
16. Was the person in poor health during the past 6 months or have a physical illness?	___	___	___
17. Has person complained often of physical ailments?	___	___	___
18. Has person ever "O.D.'d" on drugs?	___	___	___

C. Legal: Does person now have or has he/she ever had a problem with one or more of the following:

***19. Alcohol? Has use increased?**	___	___	___
***20. Illegal drugs? Has use increased?**	___	___	___
***21. Homosexuality? Does this cause guilt?**	___	___	___
***22. Breaking the law?**	___	___	___
23. Violent acts of any kind?	___	___	___
***24. Running away?**	___	___	___

III. Behavioral Observations

25. Does this person experience fatigue or anxiety without reasons?	___	___	___
26. Are eating patterns different?	___	___	___
27. Are sleeping patterns disturbed?	___	___	___
28. Is there a significant decline in school performance?	___	___	___
29. Any excessive writing of letters to friends?	___	___	___
***30. Any giving away of prized possessions?**	___	___	___
31. Any significant mood changes?	___	___	___
***32. Has this person written a suicide note?**	___	___	___
***33. Does this person admit to a suicide plan (*specific, lethal, available*)?**	___	___	___
34. Is person isolating themselves from friends or family (*staying in room, wandering alone*)?	___	___	___

***Yes to any of these items is cause for increased concern.**

NOTES: If an adolescent answers Yes to 10 or more of these items, intervention is recommended. Be alert to the severity of specific combinations, the presence of 10 items is not an absolute.

In case of previous/attempted suicide use the D.I.R.T. Assessment:
D – Dangerousness of past attempt (e.g. 3 or 50 sleeping pills)
I – Impression/Intention – what was the person's impression of the attempt, i.e. did they believe 3 sleeping pills would kill them or was it an attempt to communicate.
R – Rescue – did she/he insure availability of rescue or attempt to rescue themselves?
T- Time frame of attempt (generally speaking, the longer ago the less risk).